



Health Care Licensing Application

Assisted Living Facility - Renewal Licensure

Provider/Facility Information

Provider Information

Provider name, address, telephone number will be listed on Florida Health Finder at: <http://www.floridahealthfinder.gov/>

License Number: 10526

National Provider Identifier: 1134339260

Medicare Number:

File Number: 11966304

Medicaid Number: [REDACTED]

Provider/Facility: SWEET LIVING FACILITY INC.

Street Address

Street Address: 15505 SW 16 LANE

(Bld, Suite, Floor,
Villa, Apt)

City: MIAMI

State: FLORIDA

Zip: 33185

County: MIAMI-DADE

Telephone: (305) 228-8581

Telephone Ext:

Fax: (786) 364-1526

Provider Website: None

Email Address: avaleria197601@gmail.com

Transparency Page:

Mailing Address (All mail will be sent to this address)

Street Address: 15505 SW 16 LANE

(Bld, Suite, Floor,
Villa, Apt)

City: MIAMI

State: FLORIDA

Zip: 33185

County: MIAMI-DADE

Telephone: (305) 228-8581

Telephone Ext:

Email Address avaleria197601@gmail.com

Contact Details

Contact Person

Contact Person: Aminta Quinonez

Suffix:

Telephone: (786) 201-4302

Telephone Ext:

Fax: (786) 364-1526

Email: avaleria197601@gmail.com

Note: By providing your email address you agree to accept email correspondence from the Agency

Property Ownership

Does the licensee own or lease this facility?

Own Leased

Description of Licensee: For Profit

Ownership Type: Corporation

Licensee Name: SWEET LIVING FACILITY INC

FEIN: [REDACTED]

Mailing Address: 15505 SW 16 LANE

(Bld, Suite,
Floor, Villa, Apt.)

City: MIAMI

State: FLORIDA

Zip: 33183

County: MIAMI-DADE

Telephone: (305) 228-8581

Telephone
Ext:

Fax: (786) 364-1526

Email: avaleria197601@gmail.com

Ownership Information

 Y Does any person or entity serve as an officer of, is on the board of directors of, or have a 5% or greater ownership interest in the applicant or licensee?**Person and/or Entity Ownership of Licensee**

Full Name of Individual/Entity: ZELMIRA QUINONEZ

SSN/EIN: xxx-xxx-xxxx

Board Member/ Officer: YES

Suffix:

% Ownership: 100.00

Effective Date: 07/14/2014

End Date:

Mailing Address Type: Business

Street Address: 15505 16 LANE

(Bld, Suite, Floor, Villa, Apt)

City: MIAMI

State: FL

Zip: 33185

County: MIAMI-DADE

Telephone: (305) 228-8581

Telephone Ext.:

Email: None

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

Management Company N Does a company other than the licensee manage the licensed provider?

Personnel

First Name: ZELMIRA Middle: Last Name: QUINONEZ
Suffix: SSN: xxx-xxx-xxxx [REDACTED]
Address Type: Personal
Street Name or P.O. 15505 16 LANE (Bld, Suite, Floor, Villa, Apt.):
Box: City: MIAMI State: FLORIDA
Zip: 33185 County: MIAMI-DADE
Telephone: (305) 228-8581 Telephone Ext:
Email: None

<u>Title</u>	<u>Effective Date</u>	<u>End Date</u>	<u>FL License Number</u>
Financial Officer	7/10/2020		
First Name: AMINTA	Middle:	Last Name: QUINONEZ	
suffix:	SSN: xxx-xxx-xxxx	[REDACTED]	
Address Type:			
Street Name or P.O. 15505 SW 16 LANE	(Bld, Suite, Floor, Villa, Apt.):		
Box:	City: MIAMI	State: FLORIDA	
Zip: 33185	County: MIAMI-DADE		
Telephone: (786) 201-4302	Telephone Ext:		
Email: avaleria197601@gmail.com			

<u>Title</u>	<u>Effective Date</u>	<u>End Date</u>	<u>FL License Number</u>
Administrator	5/9/2007		

Safety Liaison

First Name: AMINTA Middle: Last Name: QUINONEZ
Effective Date: 05/09/2007 End Date:
Phone: 7862014302 Telephone Ext:
Address line1: 15505 SW 16 LANE Address line2:
City: MIAMI State: FL Zip: 33185
Email: avaleria197601@gmail.com

Required Disclosures**Convictions**

Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions or offences prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offence pursuant to subsection 408.809(1)(d), Florida Statutes? (These offences are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form (#3100-0008)).

<u>Full Name</u>	<u>SSN</u>	<u>Description</u>	<u>Exemption</u>
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Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or Federal Clinical Laboratory Improvement Amendment (CLIA) programs.

N Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

Full NameSSNDescription**Felonies / Terminations**

Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

N Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, within the previous 15 years prior to the date of this application?

N Terminated for cause from the Medicare program or a state Medicaid program.

Health and Residential Care

Y In the past 5 years, has the applicant or any controlling interest owned any entity that provided health or residential care in Florida or any other state?

If yes:

N Has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it?

Miscellaneous

N Does the owner, administrator, or any facility representative serve as 'representative payee' or as power of attorney for any Assisted Living Facility residents?

N Is the Assisted Living Facility a part of a continuing care retirement community (CCRC) pursuant to Chapter 651, F.S.? If yes, you will be prompted to attach a copy of your Certificate of Authority in the Supporting Documents section of this application.

Y Does the Assisted Living facility participate in Long Term Care, Managed Care, or MMA (Managed Medical Assistance). If yes, provide your Medicaid number below.

Medicaid #

Y Do you offer or do you plan to offer adult day care services in your assisted living facility?

Bed Count

Private Pay Beds: # OSS Beds: Total Capacity

The following information is available to consumers through the Florida Health Finder.

Room Type:**Religious Affiliation (if any):**

<input checked="" type="checkbox"/> Occupancy	6
<input checked="" type="checkbox"/> Private Beds	3
<input checked="" type="checkbox"/> Semi-Private Beds	0
<input checked="" type="checkbox"/> Bed Hold ?	Yes

Payment Forms Accepted:**Special Services Provided:**

- Insurance/ HMO
- Medicaid
- Veterans Administration

Languages Spoken:**Nurse Availability:**

- English
- Spanish

None

Special Program Provided:

- Arts and Crafts
- Dancing
- Exercise Class
- Games/Cards

Qualifications

- None
- Extended Congregate Care (ECC)
- Limited Mental Health (LMH)
- Limited Nursing Services (LNS)

I ZELMIRA QUINONEZ, under penalty of perjury, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes (F.S.), I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

(2) Pursuant to section 408.815, Florida Statutes (F.S.), I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.

(3) Pursuant to section 408.806, Florida Statutes (F.S.), the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes (F.S.).

(4) Pursuant to section 408.809 and 435.05, Florida Statutes (F.S.), every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II and Chapter 435, Florida Statutes (F.S.), and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes (F.S.), the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II or Chapter 435, Florida Statutes (F.S.), as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

ZELMIRA QUINONEZ

Signature of Licensee or Authorized Representative

OWNER

Title

10/02/2020

Date